# Patient Information

**First Name** ___________________________ **Last Name** ______________________

**Date of Birth** ____/____/___________ **Social Security** _____-____-______

**Street Address**__________________________________________________________

**City** ____________________**State** _______________ **Zip Code**________________

**Home Phone** (_____)_____-_________ **Cell Phone** (_____)_____-__________

**Preferred Number** ______________ **Sex:** Male Female

**Email:**___________________________________________________________________

**Marital Status:** Single ___ Married ___ Divorced ___ Widowed ___ Partner ___

**Race:** Asian ___ Black or African American ___ White ___ Other ___

**Ethnicity:** Not Hispanic ___ Hispanic, Latino/a ___ Other ___

***Emergency Contact***

**Name**____________________________________________________________________

**Relationship to Patient**_________________________________________________

**Address**__________________________________________________________________

**Home Phone** (_____)______-_________ **Cell Phone** (_____)______-___________

**[ ]** This person is authorized to receive health information on my behalf

# Primary Insurance

**Name of Insurance  Company:**_________________________________________

**Claim Address:**______________________________________________________

**Policy/ ID No.:**___________________________**Group No.:**_____________________

**Policy Holder Name** ___________________________________________________

**Policy Holder's Date of Birth** _____/____/______

**Relationship to Patient** ________________________________________________

**Policy Holder's Address** ______________________________________________

**Employer** _______________________________________________________________

**Policy Holder's Social Security No.  (required)** ______-_______-______

# Secondary Insurance

**Name of Insurance Company**_____________________________________________

**Claim Address** _______________________________________________________

**Policy/ ID No** ______________________________**Group No** ____________________

**Policy Holder Name** ___________________________________________________

**Policy Holder's Date of Birth** _____/_____/______

**Relationship to Patient**________________________________________________

**Policy Holder's Address**________________________________________________

**Policy Holder's Social Security No. (Required)** ______-_____-______

***Person Responsible for Bills (if different than patient)***

**Name**______________________________________________

**Relationship to Patient**____________________________________

**Address**_____________________________________________

**Phone** (____) _____-________ **Cell** (____)_____-_______

**Pharmacy**

**Name** ___________________
Address **or Crossroads** ____________________

I acknowledge that all of the information given is true and correct.

By signing below, I give Hall Medical, LLC permission to bill my insurance(s) on my behalf and am responsible for paying for all rendered services, including the amount not covered by insurance.

Patient Signature

X_________________________________ Date________________

DISCLAIMER: By typing your name above, you are signing this application electronically. You agree that your electronic signature is the legal equivalent of your manual signature on this application.

Return forms via email to office@hallmedicine.com. Sending via USPS, fax, or in person is also acceptable.